

| For Office Use Only | |
|--|----|
| No. of Certified Programs or Programs Requesting Certification | |
| Amount Enclosed | \$ |
| Date Report Received | |

AODA or MENTAL HEALTH CLINIC CERTIFICATION APPLICATION

Submission of this information is required by s. 50.065 and 51.45, Wis. Stats., and Chapters HFS 12, HFS 34 - 36, HFS 40, HFS 61 - 63 or HFS 75, Wisconsin Administrative Code. Failure to provide complete and accurate information may result in denial or revocation of certification. Questions about completion of this form may be directed to 608-243-2025 or plicmhaoda@dhfs.state.wi.us. Collection of the applicant's social security number or federal employer identification number is required per s. 73.0301, Wis. Stats. Failure to supply the number may result in denial of the application. This number will be disclosed only to the Department of Revenue for use in collection of tax delinquencies.

I. GENERAL INFORMATION – ENTITY REQUESTING CERTIFICATION

☐ Initial Certification

☐ Change Of Ownership

| | | | |
|---|-------|-----|--|
| Name – Entity or Program | | | Telephone Number |
| Entity Mailing Address (Street or PO Box, City, Zip Code) | | | Medicaid Certified <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Entity Physical Address (if different from mailing address) | | | Fax Number |
| City | State | Zip | County |
| Web Address | | | Federal Employer Identification Number or Social Security Number |
| E-mail address (if any) | | | Publish E-mail Address In Provider Directory <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Name – Owner (see Part IV. Disclosure of Ownership) | | | |
| Mailing Address – Owner (Street or PO Box, City, State, Zip Code) | | | Telephone Number |

A. Has the applicant ever been convicted of a crime involving neglect or abuse of patients, or involved in assaultive behavior, wanton disregard for health and safety of others, or any act of elder abuse under s. 46.90, Wis. Stats.?

☐ Yes – Provide an explanation on an attached sheet.

☐ No

B. Has the applicant ever had a denial, suspension, enjoining or revocation of a health care provider license, certification or approval as defined in s. 146.81, Wis Stats., or any conviction for providing health care without a license?

☐ Yes – Provide an explanation on an attached sheet.

☐ No

II. CAREGIVER BACKGROUND CHECKS

Entity Caregiver Background Checks must be completed for Entity Owners, whether or not the owner has direct client contact. They must also be completed for any board member who has direct client contact, and for non-client program residents. The on-site survey necessary for certification cannot be scheduled until the required ECBC forms are submitted to the Office of Caregiver Quality (OCQ) and certificates cannot be issued until the results are approved. If you have questions about this process, please call (608) 243-2036.

- Complete a Background Information Disclosure (BID), form HFS-64;
- Complete a Background Information Disclosure Appendix, form HFS-69; and
- Include a \$7.50 processing fee for each person, payable to "Division of Disability and Elder Services (DDES)".
- Submit all forms with appropriate fees to:

Entity Background Checks
Bureau of Quality Assurance / OCQ
2917 International Lane, Suite 300
Madison, WI 53704

III. SERVICES PROVIDED AND FEE SCHEDULE

A. CHECK BOX IN FRONT OF PROGRAMS REQUESTING CERTIFICATION:

| CSAS / AODA | | | Mental Health | | |
|--------------------------|-----------|--------------------------------------|--|-----------------------|---------------------------------------|
| <input type="checkbox"/> | HFS 75.04 | Prevention Services | <input type="checkbox"/> | HFS 61.71 | Inpatient Treatment |
| <input type="checkbox"/> | HFS 75.05 | Emergency Outpatient | <input type="checkbox"/> | HFS 61.75 | Day Treatment |
| <input type="checkbox"/> | HFS 75.06 | Medically Managed Inpatient Detox | <input type="checkbox"/> | HFS 61.79 | Adolescent Inpatient |
| <input type="checkbox"/> | HFS 75.07 | Med. Monitored Residential Detox | <input type="checkbox"/> | HFS 61.91 | Outpatient Treatment |
| <input type="checkbox"/> | HFS 75.08 | Ambulatory Detoxification | <input type="checkbox"/> | HFS 34 Subchapter II | Emergency Service 2 |
| <input type="checkbox"/> | HFS 75.09 | Residential Intoxication Monitoring | <input type="checkbox"/> | HFS 34 Subchapter III | Emergency Service 3 |
| <input type="checkbox"/> | HFS 75.10 | Medically Managed Inpatient | <input type="checkbox"/> | HFS 40 Level 1 | Day Treatment Children 1 |
| <input type="checkbox"/> | HFS 75.11 | Medically Monitored Treatment | <input type="checkbox"/> | HFS 40 Level 2 | Day Treatment Children 2 |
| <input type="checkbox"/> | HFS 75.12 | Day Treatment | <input type="checkbox"/> | HFS 40 Level 3 | Day Treatment Children 3 |
| <input type="checkbox"/> | HFS 75.13 | Outpatient Treatment | <input type="checkbox"/> | HFS 35 | Outpatient Clinic Services (proposed) |
| <input type="checkbox"/> | HFS 75.14 | Transitional Residential Treatment | | | |
| <input type="checkbox"/> | HFS 75.15 | Narcotic Treatment | PROGRAMS WITH SEPARATE FEE ASSESSMENTS* | | |
| <input type="checkbox"/> | HFS 75.16 | Intervention Services (proposed) | <input type="checkbox"/> | HFS 63 | Community Support Program |
| <input type="checkbox"/> | HFS 62 | Intox. Driver Assessments (proposed) | <input type="checkbox"/> | HFS 36 | Comprehensive Community Services |

B. FEE ASSESSMENT – THE FOLLOWING ARE THE INITIAL AND RECERTIFICATION FEES:

| No. of Programs | Fee Due w/ Application |
|-----------------|------------------------|
| 1 | \$ 350.00 |
| 2 | \$ 500.00 |
| 3 | \$ 600.00 |
| 4 | \$ 675.00 |
| 5+ | \$ 750.00 |

There are additional **Branch Office** and **Telehealth** fee assessments. Remit \$200 per requested Branch Office (available to outpatient clinics only) and \$200 for an entity's mental health and/or substance abuse treatment Telehealth Certification.

***Community Support Programs** and **Comprehensive Community Services** are separate and distinct program types. Each requires a separate application and fee of \$350, and each of which shall receive a separate certificate.

MAKE THE CHECK PAYABLE TO DIVISION OF DISABILITY AND ELDER SERVICES

IV. DISCLOSURE OF OWNERSHIP

On attached sheets, list all names, principal business addresses and percentage of ownership interest of all officers, directors, stockholders owning 5% or more of stock, members, partners, or others having authority or responsibility for the operation of the organization. For non-profit organizations or governmental organizations, list the names and principal business addresses of all officers and board members. **If there are no additional owners, see Part I, check here ☐.**

V. AFFIRMATION

I understand, under penalty of law, that the information provided above, and in attached application materials, is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a fine of up to \$10,000 or imprisonment not to exceed 6 years, or both (946.32 Wis. Stats.) I swear or affirm that I will comply with all laws, rules and regulations governing program certification in Wisconsin.

Print or Type Name

SIGNATURE (In Full) - Designee

Date Signed

TITLE (Must be Owner or Board Member)